

# Chapters 44, 45, and 46

## Medicaid Rules Implementation

Wyoming Department of Health  
Division of Healthcare Financing  
Developmental Disabilities Section



- Welcome
- Introduction of presenters
- If you have questions, please type them into the chat box and we will address them at the end of the presentation.
- This presentation will be available on the Division website for future reference.

## Process and Timeline

⇒ Rules Advisory Committee – February - April 2019

⇒ Community Engagement Sessions – May - June 2019

- Casper
- Gillette
- Sheridan
- Cody
- Lander

- Jackson
- Evanston
- Laramie
- Cheyenne

⇒ Public Comment – September 18 - November 1, 2019

⇒ Effective – December 20, 2019

- The Division followed a rigorous process in order to obtain feedback on Chapters 44, 45, and 46 of the Department of Health's Medicaid Rules.
- The Division assembled a Rules Advisory Committee, which met from February through April of 2019.
  - The Division sought applications for committee membership in October and November of 2018.
  - Division representatives appointed members in November 2018.
  - The committee met every other week for at least 2 hours to review the Chapters.
  - The committee was tasked with:
    - Identifying sections of the rules that needed clarification, and
    - Developing recommendations for revisions to rules that were perceived as creating barriers for the individuals receiving services.
  - The Division reviewed all recommendations and drafted revisions.
- In May and June of 2019, the Division conducted community engagement sessions around Wyoming to obtain input on the Chapters.
  - These sessions were held in Casper, Gillette, Sheridan, Cody, Lander, Jackson, Evanston, Laramie, and Cheyenne.
  - The Division also held a phone conference for people who were unable to attend one of the in-person sessions.
- The rules were released for public comment on September 18, 2019. The public comment period ended at 5PM on Friday, November 1st.
- The rules were promulgated and are effective as of December 20, 2019.

# Public Comment and Responses

The Division received comments from ten individuals, two organizations, and one association.

- ⇒ A list of comments received and the Division's responses can be found on the Public Notices, Regulatory Documents, and Reports page of the Division website at <https://health.wyo.gov/healthcarefin/dd/dd-public-notice/>.
- ⇒ Stakeholders are encouraged to review the Chapters, in their entirety, to have a better understanding of all of the revisions that have been made.
- ⇒ Address questions with your area [Provider or Participant Support Specialist](#).

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- During the public comment period, the Division received comments from 10 individuals, 2 organizations, and 1 association. There were not enough requests to warrant a public meeting.
- A list of the comments that were received, as well as the Division's responses to those comments, can be found on the Division website, which is listed on the slide.
- Providers, case managers, and other stakeholders are strongly encouraged to read Chapters 44, 45, and 46 in their entirety. While we will be going over the more impacting changes to the rule, we will not be addressing each and every change that was made. People impacted by these rules will be expected to comply with all changes, even if we don't specifically address them during this presentation.
- If you have questions about these Chapters or the changes that have been made, please contact your area Provider or Participant Support Specialist.

# Overall Revisions to Chapter 44, 45, and 46

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Before we get into the specific Chapter revisions, let's go over some of the revisions that overarched all three Chapters.

## Overall Revisions to All Chapters

- ⇒ “Division” is now defined as the Division of Healthcare Financing.
- ⇒ Rules align with waiver renewals, including changes to service names.
- ⇒ References to “facilities” as they relate to home and community based settings have been replaced with “services settings” or “settings”.
- ⇒ Language, formatting, and punctuation have been cleaned up.
- ⇒ Sections that were not necessary in rule (philosophy, methodology, purpose) have been removed.
- ⇒ Chapters 44 and 46 have been renumbered

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- On August 16, 2019 the Department of Health reorganized, and the Developmental Disabilities Section was moved under the Division of Healthcare Financing. The definition of Division has been changed to reflect this move.
- In April 2019, new Comprehensive and Supports Waivers were approved by the Centers for Medicare and Medicaid Services. The new rules have been changed to align our federal and state authorities. Wherever possible, we have incorporated subregulatory guidance, such as the Comprehensive and Supports Waiver Service Index, so that we don’t have to amend rules when changes are made to the waivers.
- The word “facilities” has a very institutional undertone, and is now present in these Chapters only when referring to institutions like the Wyoming Life Resource Center. We have replaced other references to “facilities” with “setting” or “service setting” to come into alignment with home and community based philosophy
- Anytime we open up a document for revision, we look for ways to improve upon language and formatting, and have done so in these Chapters.
- The Division worked closely with the Attorney General’s office when revising these rules. They recommended removing some of the Sections that were not rule based. Sections referring to philosophy, methodology, purpose, or similar topics have been removed.
- Finally, due to changes within Chapters 44 and 46, which we will discuss later in the presentation, these Chapters have been renumbered.

# Chapter 44 — Environmental Modifications and Specialized Equipment for Medicaid Home and Community Based Waiver Services

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Chapter 44 establishes rules for environmental modifications and specialized equipment for Medicaid home and community based waiver services.

## Chapter 44 Revisions

**Section 4(a)(ii)** - addresses the scope and limitations of environmental modifications

- ⇒ Contribute to a person's ability to remain in or return to his or her home and out of an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) **or other institutional setting.**

**Previous Section 9 and 10** - addressed self-directed goods and services

- ⇒ Removed both Sections - they related to self-directed goods and services, which is no longer a service option on the Comprehensive or Supports Waivers.

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The specific revisions to Chapter 44 were fairly minor.

- Section 4 addresses the scope and limitations of environmental modifications.
  - One purpose of environmental modifications is to allow participants to remain in their home rather than in an institution.
  - Prior to the revision, this provision of rule was specific to keeping people from entering an intermediate care facility of individuals with intellectual or developmental disabilities.
  - Subsection (a)(ii) has been revised to clarify that environmental modifications should contribute to a person's ability to remain out of other institutional settings, such as nursing facilities, as well.
- Previous Sections 9 and 10 established rules for self directed goods and services. These sections have been removed since self-directed goods and services is not a service option on the Comprehensive or Support Waivers.

# Chapter 45 – DD Waiver Provider Standards, Certification, and Sanctions

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Chapter 45 establishes rules concerning DD waiver provider standards, certification, and sanctions.

# Aligning National Accreditation Standards with Medicaid Rules

**Providers meeting the criteria outlined in Section 25 must obtain and maintain national accreditation.**

- ⇒ Providers required to meet national accreditation standards must meet those requirements *in addition to* requirements outlined in Chapter 45.
- ⇒ If national accreditation standards and standards in Wyoming Medicaid Rule do not align, the provider must meet the more stringent of the two authorities.

- Although this Chapter establishes rules for all Wyoming Waiver providers, some providers must also obtain and maintain national accreditation.
- These criteria are outlined in Section 25, which we will go over later in the presentation.
- Providers who meet these criteria must meet the standards established by their accrediting agency, even if those standards are not specifically outlined in Wyoming Medicaid Rule.
- If standards established in Wyoming Medicaid Rule do not align with national accreditation standards, the provider should meet the more stringent of the two authorities.
- As an example, if Chapter 45 establishes that emergency plans must be reviewed once a year, and the accrediting agency requires a review of the emergency plan once a quarter, the provider should meet the more stringent requirement of a quarterly review.

## Section 4 – Rights of Participants Receiving Services

**Protecting the rights of waiver participants is a critical component of home and community based services.**

- ⇒ Section 4(b) – ...A participant's right to dignity and respect, to be free from coercion, and to receive services in settings that are physically accessible to the participant shall not be limited or restricted.

Section 4 addresses the rights of participants receiving services.

- Protecting the rights of waiver participant's is a critical component of home and community based services
- A person's right to dignity and respect and to be free from coercion should never be restricted. Additionally, the Centers for Medicare and Medicaid Services has established in Title 42 that a person's right to receive services in a setting that is physically accessible to them cannot be restricted. These basic tenets are outlined in subsection (b).

## Section 4 – Rights of Participants Receiving Services

**A person's right to be free from restraints shall only be limited if certain criteria are met.**

- ⇒ Section 4(d) – A restriction on the right to be free from restraint shall be accompanied by letters from a licensed medical and behavioral professional that detail medical and psychological contraindications that may be associated with a restraint.
- ⇒ Beginning January 1, 2020, letters are required at the time an individualized plan of care or modification is submitted.

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Section 4 addresses the rights of participants receiving services.

- A person's right to be free from physical, mechanical, and chemical restraints shall not be denied or limited unless a court, the participant, or the participant's legally authorized representative authorizes the denial or limitation in writing.
- Any time a restraint is performed, there is a risk of participant injury or traumatization. Before a restraint is performed, providers should be aware of the participant's medical and psychological concerns
- Subsection (d) establishes that rights restrictions must be accompanied by letters from a medical and behavioral professional that detail the medical and psychological contraindications that may be associated with a restraint.
  - The Division is not requesting that teams seek permission from licensed professionals.
  - The letter from a professional is not all that is required for a rights restriction.
  - If a restraint is part of a person's plan, it is important for the team, and especially the provider that may be performing the restraint, to understand the medical and psychological concerns that are present.
    - Concerns such as brittle bones or respiratory challenges may be included in a letter from a medical professional.
    - Past trauma or aversion to touch may be outlined in a letter from a behavioral professional.
    - If there aren't any concerns, that should be noted in the letter(s) as well.
  - The Division presumes that, if a participant has restraint written into their

- plan of care, that they will have a medical and behavioral professional included on their team.
- Beginning January 1, 2020, the case manager is required to upload these letters at the time an individualized plan of care or modification is submitted.

## Section 5 – Provider Qualifications for Each Waiver Service

**Individual waiver providers, subcontractors, and provider employees must meet specific qualifications, based on the service they are providing.**

- ⇒ Section 5(b)(i) – A Behavioral Support Services provider or provider staff shall meet credentials as outlined in the Comprehensive and Supports Waiver Service Index, which is incorporated by reference.

Section 5 establishes provider qualifications for each waiver service.

- Individual waiver providers, subcontractors, and provider employees must meet specific qualifications, based on the service they are providing.
- The Division has included a new definition for behavioral support services in the waiver amendment that is waiting for approval from the Centers for Medicare and Medicaid Services. This new definition establishes tiered services that can be performed by certified providers with differing qualifications, depending on the tier level.
- The final service that is approved will be reflected in the Comprehensive and Supports Waiver Service Index.
- The rule that establishes the provider qualifications for behavioral support services now refers back to the Service Index to ensure all authorities align.

## Section 6 – Standards for All Providers

**Chapter 45 establishes specific policies that providers are required to develop, follow, and share with others.**

- ⇒ Section 6(a)(xi)(A) – Establish and implement written policies and procedures that:
- Are available to staff, participants, ***legally authorized representatives*** and, ***upon request***, the general public.

Section 6 is establishes standards for all providers.

- Chapter 45 establishes specific policies that providers are required to develop, follow, and share with others.
- Although the expectation has always been that provider policies must be available to legally authorized representatives, this revision clarifies that expectation.
- Past versions of Chapter 45 required providers to share the policies that were required by rule with the general public. This subsection now clarifies that the policies need to be shared only upon request.

## Section 7 – Provider Recordkeeping and Data Collection

**Maintaining records and data is an essential requirement of all waiver providers.**

⇒ Section 7(d) – ...The provider shall retain all records relating to the participant and the provision of services ***in accordance with Chapter 3 of the Department of Health's Medicaid Rules.***

- Chapter 3 establishes the rules for Provider Participation.
- Providers must maintain medical and financial records, including information regarding dates of services, diagnoses, services furnished, and claims, for at least six (6) years after the end of the state fiscal year in which payment for services was rendered.

Section 7 outlines the requirements for provider recordkeeping and data collection.

- Maintaining records and data is an essential requirement of all waiver providers.
- Past record retention requirements aligned with Chapter 3 of the Department of Health's Medicaid Rules, which establishes the record retention requirements for Medicaid providers.
- Rather than repeating what is established in Chapter 3, this Chapter is now specifically cited in this provision of rule. This will alleviate any conflict between authorities if Chapter 3 rules change.
- The records retention timeline established in Chapter 3 requires a provider to maintain medical and financial records, including information regarding dates of services, diagnoses, services furnished, and claims, for at least six years after the end of the state fiscal year in which payment for services was rendered.

## Section 8 – Documentation Standards

**Specific information is required each time a service is documented in written or electronic form.**

- ⇒ Section 8(f) – The following information shall be included each time a services is documented:
- (i) The location of services;
  - (ii) The date of service, including year, month, and day;
  - (iii) The time services begin and end, using either AM and PM or military time, with documentation for each calendar day, even when services span a period of longer than one day;
  - (iv) An initial or signature of the person performing the service; and
  - (v) A detailed description of services provided...

Section 8 addresses documentation standards.

- Providers are required to capture specific information each time a service is documented. This requirement applies to written and electronic documentation.
- In previous iterations of rule, the provision of this subsection stated that this was only required for written documentation.
- However, it has always been a Division expectation that the date, time, and location of the service, as well as a description of the service and identification of the person delivering the service is included in the documentation, regardless of if the documentation is written or electronic.
- The reference to “written documentation” in this subsection has been removed to clear up any confusion.

## Section 9 – Case Management Services

**Case managers are responsible for ensuring that information in the plan of care is accurate and up-to-date.**

- ⇒ Section 9(d) – The case manager shall assure that all information, including but not limited to ***guardianship paperwork*** and physical and mailing addresses of the participant, legally authorized representative(s), ***and other contacts*** is updated and accurate at all times. The case manager shall update the Division and other providers of any changes.

Section 9 addresses case management services.

- Case managers are responsible for ensuring that the information in each participant's plan of care is up-to-date and accurate. This includes addresses, phone numbers, email addresses, and any other contact information for people identified in a participant's circle of supports.
- It is also the responsibility, to the extent that the case manager is knowledgeable, that current guardianship documents are uploaded in the Electronic Medicaid Waiver System (EMWS). Subsection (d) clarifies these expectations.

## Section 9 – Case Management Services

**Case managers are responsible for providing participant specific training to all providers listed on the individualized plan of care.**

- ⇒ Section 9(e)(vii) – ...Documentation of participant specific training shall be available to the Division upon request.

- One of the case manager's tasks is to complete participant specific training for providers who are listed on the participant's plan of care.
- The case manager should obtain evidence that this training has occurred, and the evidence or documentation of the training must be available to the Division as requested.
- Although this has always been expected, subsection (e)(vii) makes the expectation clear.

## Section 10 – Individualized Plan of Care

**In order to ensure the plan of care is comprehensive and person centered, all team members need to be involved in the plan of care meeting.**

- ⇒ Section 10(c) – The case manager shall provide **written** notice of the plan of care meeting to all team members at least **twenty (20)** calendar days prior to the meeting.
- ⇒ **Section 10(f)** – The individualized plan of care shall include information addressing a provider's inability to provide any of the supports outlined in subsection (e) of this Section.

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Section 10 addresses the individualized plan of care, including the team meeting process and the specific components that should be included in the plan.

- In order to ensure the plan of care is comprehensive and person centered, all team member need to be involved in the plan of care meeting.
- Case managers have always been required to provide team members with notice of plan of care meetings. Section 10(c) requires that the notification be provided in writing.
- Case managers must provide the notification at least 20 days prior to the meeting, which is a change from the 30 days notice they have had to provide in the past.
- The Division has always required that the plan of care include information addressing a provider's inability to provide any of the supports that are addressed in the IPC.
- However, this provision was somewhat buried, so we have moved the location of the provision to subsection (f) so it is more clearly established.

# Section 13 —

Standards for Home and  
Community Based Services

- (a)
- (e)(i)
- (f)
- (g)
- (h)(xii)
- (h)(xiii)
- (h)(xv)(C)

Section 13 addresses Standards for Home and Community Based Services. This is the longest Section of Chapter 45, and did undergo revisions is several subsections.

## Section 13(a) – Provider Owned and Operated Settings

**Providers offering services in a provider owned or operated setting must meet all applicable federal, state, city, county, and tribal health and safety codes.**

- ⇒ Certified waiver providers offering direct care services to participants in a provider owned or operated services setting shall meet all applicable federal, state, city, county, and tribal health and safety code requirements. A service setting includes the provider's home, if services are ***routinely*** provided in that setting.

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- Many of the provisions in this Section are specific to provider owned and operated settings.
- Providers offering services in a provider owned or operated setting must meet all applicable federal, state, city, county, and tribal health and safety codes.
- As established in Section 13(a), a provider owned and operated setting will include a provider's home if services are routinely provided in the setting.
- The Division is defining "routinely" as more than once a month.
- The Division understands that, as part of a typical life, participants often build relationships with providers and provider staff members. The "routinely" that has been added to this subsection allows participants to spend the occasional holiday, birthday, or special occasion with a favorite staff member, and still allow the provider to be paid for the service that is being provided.
- This change is meant to provide more flexibility for the participant, and is not intended as way for the provider to skirt around the requirements that are established in this Section.

## Section 13(e)(i) – Inspections by Outside Entities

**Providers are required to obtain an inspection from an outside entity, such as a fire marshal, building inspector, or contractor.**

- ⇒ For each location where services are provided to a participant, the provider shall obtain an inspection of the service setting by an outside entity at least once every **twenty-four (24) months**. The Division may require more frequent inspections if the Division suspects that the service setting would not pass the inspection.
- ⇒ An inspection by an outside entity that has occurred within twenty-four months must be submitted at the time of the provider's next certification renewal.

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- Section 13(e) addresses provider inspections of their service settings.
- Providers are required to obtain an inspection from an outside entity, such as a fire marshal, building inspector, or contractor.
- This inspection must now occur every 24 months, which is more often than the 36 months previously established in rule.
- As a reminder, if the provider is required to maintain national accreditation the provider should follow the most stringent timeline for this requirement.
- The Division may require more frequent inspections if we suspect that the setting would not pass the inspection
- An inspection by an outside entity within twenty-four months must be submitted at the time of the provider's next certification renewal.

## Section 13(f) – Annual Self Inspections

**Providers offering services in a setting they own or operate must complete an annual self inspection to verify that they are in compliance with Section 13.**

- ⇒ A provider offering services in a setting they own or lease shall complete an annual self-inspection of the setting to verify that the provider is in compliance with this Section, ***and address any deficiencies found.***

- Section 13(f) requires providers to complete annual self-inspections.
- Providers offering services in a setting they own or operate must complete an annual self inspection to verify that they are in compliance with Section 13
- The Division has always expected providers to address the deficiencies found during self inspections, but this is now specifically clarified in rule.

## Section 13(g) – Emergency Plans

- (i) Providers shall have written emergency plans and procedures for:
- (A) Fires;
  - (B) Bomb threats;
  - (C) Natural disasters, including but not limited to earthquakes, blizzards, floods, tornadoes, wildfires;
  - (D) Power and **other utility failures**;
  - (E) Medical emergencies;**
  - (F) Missing person;**
  - (G) Provider incapacity;**
  - (H) Safety during violent or other threatening situations;
  - (I) Staffing shortages due to other emergency situations;**
  - (J) Vehicles emergencies; and
  - (K) If applicable, how the provider is able to care for or provide supervision to participants and children under the age of 12.

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- Section 13(g) establishes the emergency plans that providers are required to develop and review.
- There have been several additions to required emergency plans
  - A plan for other utility failures;
  - A plan for provider incapacity; and
  - A plan for staffing shortages due to other emergency situations.
- In previous iterations of rule, plans for medical and behavioral emergencies, as well as a plan for missing persons, were listed together. A plan for behavioral emergencies has been eliminated, as these emergencies will most typically fall into another category, and a plan for a missing person has been moved from the medical emergency, and is now listed separately.

## Emergency Plans – Other Utility Failures

⇒ (i) Providers shall have written emergency plans and procedures for:  
(D) Power and ***other utility failures***;

⇒ Other utility failures could include, but are not limited to:

- Water and sewer services
- Natural gas
- Propane
- Well or septic systems

- While the Division has always required the provider to have an emergency plan for a power failure, we have now included other utility failures.
- What happens if the setting doesn't have running water or the sewer line is plugged for several days?
- What if the setting has a furnace that runs on natural gas and gas service is interrupted?
- Providers should think through these scenarios and have plans to address these emergencies.

# Emergency Plans – Provider Incapacity

⇒ (i) Providers shall have written emergency plans and procedures for:  
(G) ***Provider incapacity;***

⇒ Things to consider

- If a participant receives individual services, and the provider delivering the service becomes incapacitated during that time, does the participant know how to call for help?
- Is there a formal staff or provider check in process, or is another staff member scheduled to relieve the staff?
- What are the safety concerns for the participant if they are left alone for a period of time?

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- A plan for provider incapacity is extremely important.
- What if tragedy strikes and an independent provider or provider staff member who works one on one with a participant is incapacitated or dies?
- The plan should address how the provider will address the safety of the participant or participants in such an event.
- The plan should be developed keeping considerations such as the participant's ability to call for help, or the risk of the person being without supervision or support for any length of time, in mind.

# Emergency Plans – Staffing Shortages

- ⇒ (i) Providers shall have written emergency plans and procedures for:
  - (I) ***Staffing shortages due to other emergency situations;***

- ⇒ Things to consider

- How will the provider or provider staff support other participants if they are called away to handle a crisis?
- Does the provider have an on-call system to respond to crisis situations? How long will it take another staff member to respond?

- When emergencies require staff to respond to one or two individuals, but there are other participants receiving services in that setting, it can result in an immediate staffing shortage.
- How does the provider assure that the needs of all individuals are met?
- This should be addressed in a plan for staffing shortages due to other emergency situations.

## Emergency Plans – Additional Notes

- ⇒ All providers must have plans for all situations outlined in Chapter 45, Section 13(g)(i).
- ⇒ Plans may look different from provider to provider, depending on their specific situation and approach to service delivery.
- ⇒ Plans should be developed no later than April 1, 2020.
- ⇒ For questions regarding emergency plans, contact your area [Provider Support Specialist](#).

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- All providers will need to have emergency plans for all situations outlined in rule.
- The provider will be responsible for developing emergency plans that are appropriate for their specific situation and approach to service delivery.
- If you have questions about emergency plans, or would like to have your emergency plans reviewed, please contact your Provider Support Specialist.
- Providers should develop and begin reviewing these plans by April 1, 2020. Demonstration of plan reviews will be examined during your next provider certification renewal.

## Section 13(g) – Emergency Plan Review

**Providers must review emergency plans with participants and staff members.**

- ⇒ (iii) – The provider shall document the review of all applicable emergency plans, with staff and participant's at least once every twelve (12) months on ***routine*** shifts.
- ⇒ (iv) – This subsection referred to non 24-hour services. This subsection has been removed, as subsection (iii) addresses both 24-hour and non 24-hour services.

- In addition to developing emergency plans, the provider must also review the plans with participants and staff members.
- Rather than addressing the review of emergency plans based on 24-hour services vs. non 24-hour services, rule now dictates that emergency plans must be reviewed with staff and participant's at least every 12 months on "routine" shifts.
- The provider will be responsible for defining a routine shift based on their particular circumstances, but it is expected that all participants and staff members will be included in the review process.

## Section 13(h)(xii) – Remote Support

**When technology is used as a support for a participant, other participants who receive services in the same setting can be impacted.**

- ⇒ Providers shall not use video monitors in participant bedrooms or bathrooms. Other forms of remote monitoring, remote support, or sensors may be used where appropriate, and shall be documented in the participant's individualized plan of care.
  - (A) The consent of participants who share living quarters and may be affected shall be obtained prior to the implementation of remote support or monitoring.
  - (B) Consent shall be documented in each participant's individualized plan of care, which is verified by the plan of care team.
- ⇒ Effective at next plan review or modification.

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- Remote support is a new option for community living services, and the Division is excited about the potential this support has to increase participant independence and decrease the need for some participants to rely on constant staff interventions.
- Anytime technology is used as a support for a participant, other participants who receive services in the same setting can be impacted.
- If a participant is receiving remote support as a part of their services, Section 13(h)(vii) requires that other individuals who receive services in the setting also give consent.
- This consent should be listed in the IPC for the person directly receiving the remote support as well as the participants who are in the setting but not directly receiving the remote support, and will be required the next time a participant's plan is reviewed or modified.

## Section 13(h)(xiii) – Potable Well Water

**Providers that use a private well must ensure that water is safe to drink.**

- ⇒ A provider service setting with a private water supply shall have testing conducted every three (3) years to demonstrate that the ***water is safe to drink***. The written results shall be submitted to the Division within thirty (30) calendar days of receiving the results.

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- Providers that use a private well must ensure that the water is safe to drink.
- Past iterations of rule have required providers offering services in a setting with a private water supply to have bacterial testing conducted every three years.
- The phrase “bacterial testing” has at times caused confusion in terms of what the Division was looking for.
- The intent of the rule is to make sure that water is safe for human consumption. Section 13(h)(xiii) has been changed to clarify this intention.
- A company licensed to conduct the testing will need to provide written results of this testing, and the provider will need to submit the written results to the Division every three years.

## Section 13(h)(xv)(C) – Weapons Policy

**If weapons are present in a service setting, weapons and ammunition must be stored separately.**

- ⇒ A weapons policy that includes the requirements that weapons are stored in a locked cabinet or inaccessible location, and ammunition is stored separately from ***weapons***.

- Subsection 13(h)(xv) addresses written policies to address participant health, safety, and rights.
- Specific policies regarding smoking, pets, and weapons are addressed in this subsection.
- If weapons are present in a service setting, weapons and ammunition must be stored separately.
- The weapons policy developed by the provider must include that ammunition of any kind is stored separately from any weapon. This is not specific to firearms, but includes any weapon that uses ammunition of any kind.

## Section 14 – Background Check Requirements

**Providers, staff members, and entities supervising, providing, or billing for waiver services must pass a background screening.**

- ⇒ Section 14(e)(iii)(A)(VI) – **Human trafficking (W.S. 6-2-701)**
- ⇒ Section 14(f) – At the discretion of the provider or employer of record, an individual staff member may provide unsupervised services on a provisional basis to a participant who is eighteen (18) years or older following the submission of the background screening, as long as disqualifying crimes or relevant criminal records are not disclosed on the application, until the individual staff member is cleared through successful background screenings.

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Section 14 establishes the requirements for background screenings.

- Certified providers, their employees, and all legal entities supervising, providing, or billing for waivers services, including self-directed employees, must pass and maintain documentation of a successful background screening, which includes a Department of Family Services Central Registry screening, an Office of Inspector General Exclusion Database screening, and a state and national fingerprinted criminal history record check.
- This Section has been updated to include human trafficking as a barrier crime.
- The Division has received a great deal of feedback regarding the time it takes to get results of background screenings. This delay in the hiring or certification process increases the time it takes to get providers and provider staff delivering services, which can be detrimental to participants. Delays in hiring can also potentially cause safety issues for participants.
- In response to this concern, Section 14 has been changed to allow providers and employers of record to, at their discretion, allow individual staff members to provide unsupervised services to participants on a provisional basis before the results of a background screening are received, on the following conditions:
  - The participant must be 18 years or older;
  - The applicant must not have disqualifying crimes, which are specifically listed in Section 14, or relevant criminal records disclosed on the application; and

- The background screening must have been submitted as required.
  - The staff member or employee must meet all other requirements as outlined in other Sections of Chapter 45.
- If the provider staff or self-directed employee fails the background screening, the staff member or employee must immediately desist from providing services or having unsupervised access to the participant.
  - The provider or employer of record will not be required to pay back the funds billed during the provisional time as long as all rule requirements related to the provisional service delivery were met.

## Section 14 – Background Check Requirements

**Subsequent background screenings are now required.**

- ⇒ Section 14(n) – The Division shall require subsequent background screenings as outlined in this subsection. Any person who fails to pass a subsequent background screening shall not supervise, provide, or bill for waiver services.
- An individual required to receive a background screening under this Section shall undergo subsequent background screenings every five (5) years.
  - Providers and any person with an ownership or control interest or who is an agent or managing employee of the provider shall undergo subsequent monthly Office of Inspector General (OIG) Database screenings.

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- An initial background screening of providers and employees has been required for many years. However, we all know that a lot can happen over time. A subsequent background screening every 5 years is now required for all individuals who are required to undergo an initial background screening pursuant to this Section.
  - The five years is calculated based on the date the last background check results were issued.
  - Providers will have until December 31, 2020 to come into compliance with this rule.
- Federal law requires that providers and certain positions within provider organizations undergo subsequent Office of Inspector General (OIG) Database screenings every month. These positions include persons with an ownership or control interest or who are agents or managing employees of a provider. The provider is required to conduct these screenings and maintain documentation that demonstrates these screenings have occurred as required.
- Subsequent background checks will be reviewed during provider certification renewals, and can be requested at any time by the Division.

# Positions Required to Undergo Monthly OIG Screenings

- ⇒ Individual providers
- ⇒ Sole proprietors
- ⇒ Chief Executive and Chief Financial Officers
- ⇒ Employees responsible for submitting billing for services
- ⇒ Direct support **supervisors**

*Staff member who only provide direct services are not required to undergo monthly OIG screenings.*

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- Although this list isn't inclusive, the following list is an example of positions that may be required to undergo the monthly Office of Inspector General screening:
  - Individual providers;
  - Sole proprietors;
  - Chief Executive and Chief Financial Officers;
  - Employees responsible for submitting claims; and
  - Direct support supervisors.
- Direct support staff are not required to undergo subsequent monthly OIG screenings as long as they don't meet the definition of a person with an ownership or control interest or who is an agent or managing employee of a provider.

# Background Screening Timelines

**The Division will allow providers a reasonable amount of time to come into compliance with this change in rule.**

- ⇒ **December 31, 2020** - Providers must have the background check results for all individuals required to undergo subsequent five year background screenings.
  - Compliance must be ongoing after this date.
- ⇒ **April 1, 2020** - Documentation of monthly OIG Exclusion Database screenings must be available for all individuals subject to this requirement.

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- The Division understands that it will take providers time to come into compliance with this rule change.
- As of December 31, 2020, providers must have the background results for all individuals who required to undergo subsequent background screenings. This will allow providers to a chance to catch up if they have staff members who have already been in services for five or more years.
- After this date, providers must be in compliance with this rule at all times.
- As of April 1, 2020, providers must be able to present documentation showing that individuals subject to monthly OIG Exclusion Database screenings are being checked each month.

# Background Screening Resources

- ⇒ Background screening website:  
<https://health.wyo.gov/admin/background-screening/>
- ⇒ OIG Exclusions Database search:  
<https://exclusions.oig.hhs.gov/>
- ⇒ [42 CFR § 455.436 - Federal database checks](#)
- ⇒ [42 CFR § 455.101 - Definitions](#)

- The link to the Department of Health Background Screening website can be found on the slide. This webpage offers more information on the Wyoming background screening process.
- The Office of Inspector General Exclusions Database link is also on the slide. Both of these links can also be found on the Division website.
- To view the federal guidance and definitions for the OIG Exclusions Database, we encourage you to click on the links provided.

## Section 15 – Provider Training Standards

**Providers and provider staff members must receive comprehensive training, and be able to demonstrate they they understand the training they received.**

- ⇒ Section 15(d) – All persons qualified to provide waiver services shall complete training in the following areas ***prior to delivering services***.
- ⇒ Section 15(g)(v) – Documentation of participant specific training and general training shall include ***how the person receiving training demonstrated understanding***.
  - Competency test
  - Skill demonstration observed by supervisor, who documents the observation
  - Documented discussion or explanation of expectations

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Section 15 establishes provider training standards.

- Providers and provider staff members must receive comprehensive training, and be able to demonstrate they they understand the training they received.
- It is critical that all providers and provider staff receive necessary training before they deliver waiver services. Subsection (d) clarifies this requirement.
- Subsection (g)(v) establishes that the provider's documentation on participant specific training must include how the person receiving the training actually demonstrated understanding of the training received.
- It is up to the provider to decide how the person receiving the training will demonstrate understanding. Examples of how understanding can be demonstrated include, but are not limited to:
  - A competency test;
  - A demonstration of the skill, which is observed by supervisor and documented; or
  - A discussion or explanation of what is expected, which is then documented by the supervisor.

## Section 17 – Positive Behavior Supports

**If a participant's behavioral emergency results in the use of restraint or law enforcement being called, then it is presumed that the positive behavior support plan has failed.**

- ⇒ Section 17(g) – If restraints are used **or law enforcement is contacted** due to a behavioral emergency, the positive support plan has failed and must be reviewed to possibly add or modify the service environment or behavioral interventions.
- ⇒ A behavioral emergency is a situation in which the participant's behavior puts them or others in danger, and a restraint or the assistance of law enforcement is needed to ensure the immediate physical safety of everyone involved.

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Section 17 addresses positive behavior supports.

- If a participant's behavioral crisis results in the use of restraint or law enforcement being called, then it is presumed that the positive behavior support plan has failed.
- In past versions of rule, the Division has required teams to review the positive behavior support plan if restraints are used.
- Many providers have chosen to be restraint-free organizations. If a behavioral crisis arises, these providers often contact law enforcement to help with the situation.
- Although restraints may not be performed in this instance, the need to call law enforcement also indicates that the positive behavior support plan has failed.
- Subsection (g) requires that teams review the positive behavior support plan when law enforcement is contacted due to a behavioral emergency.
- A behavioral emergency is a situation in which the participant's behavior puts them or others in danger. If a restraint is used, or law enforcement is contacted in order to manage the crisis and to ensure the immediate physical safety of everyone involved, this situation would be considered a behavioral emergency.

## Section 18 – Restraint Standards

**Restraints should only be used when the risk of injury without restraint is greater than the risk associated with performing a restraint.**

- ⇒ Section 18(o)(v) – A provider using restraints shall:
- If an injury occurs as a result of a restraint, conduct staff re-training within five (5) business days of the injury being detected.

Section 18 establishes restraint standards.

- Restraints are a last resort in responding to an emergency situation. They should only be used when the risk of injury without restraint is greater than the risk associated with performing a restraint.
- Any time a restraint is performed there is a chance that an injury could occur.
- Section 20, which addresses incident reporting, already requires providers to report to the Division and other parties, the use of restraint as well as any injury to the participant that is caused by a restraint.
- However, if an injury occurs during a restraint, it is in the best interest of participants and providers to conduct retraining to ensure that the staff members involved in the restraint are proficient and comfortable with the restraints that are being performed.
- This provision has been included in subsection (o)(v).

## Section 20 – Notification of Incident Process

The requirements of this Section haven't changed, but have been rearranged.

### Section 20(b)(vii)

- ⇒ Providers shall report the following incidents to the Division, Protection and Advocacy System, Inc., the case manager, and legally authorized representative(s) within one (1) business day:
- Medication errors that result in emergency medical attention;

### Section 20(c)

- ⇒ Providers shall report the following medication errors to the Division, the case manager, and legally authorized representative(s) within three (3) business days:

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Section 20 outlines the notification of incident process.

- The requirements in this Section haven't really changed, but they have been rearranged.
- Subsection (b)(vii) requires that medication errors that result in emergency medical attention must be reported within one business day.
- Other medication errors must be reported within three business days, so this information has been moved to its own subsection of rule.

## Section 21 – Complaint Process

**The Division can require the provider to submit a corrective action plan as a result of a complaint.**

- ⇒ Section 21(e) – A provider's failure to ***submit and successfully implement*** an approved corrective action plan, as outlined in Section 29 of this Chapter, may result in sanctions per Section 30 of this Chapter.

Section 21 addresses the Division's complaint process.

- If, as a result of a complaint filed with the Division, the provider is found to be in violation of rules, the Division can require the provider to submit a corrective action plan.
- It has always been the expectation that provider corrective action plans that are required by the Division as a result of a complaint must be submitted and implemented.
- This wording to subsection (e) has been added to this Section to alleviate all doubt.

## Section 22 – Transition Process

### A provider has the right to terminate services with a participant

#### Section 22(b)

- ⇒ A provider who is terminating services with a participant shall notify the participant **and the Division** in writing at least thirty (30) calendar days prior to ending services, unless the Division approves a shorter transition period in advance...
- ⇒ Contact the area Provider Support Specialist.

#### Section 22(d)

- ⇒ When a transition is requested, the case manager shall notify the Division of the request for change within **three (3)** business days of the request;

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Section 22 establishes the provider and case manager transition process.

- Participants and legally authorized representatives may choose to change any provider at any time for any reason.
- Providers also have the right to terminate the services they provide for a participant.
- A provider who is terminating services has always been required to notify the participant at least 30 days before services end. However, it is critical that the Division be made aware of this decision as well. Notification to the Division has been added in subsection (b).
- For the purposes of this rule, the provider should contact the area Provider Support Specialist.
- When a participant requests a transition, case managers now have three business days to notify the Division. This is a change from the five business days they had in previous iterations of rule.

## Section 25 – Additional Standards for Providers that Require National Accreditation

### Provisions that will change:

- ⇒ Established for providers certified in adult day, case management, community living, community support, companion, and supported employment services.
- ⇒ Required if services listed above and delivered by the provider collectively equal or exceed \$150,000 per calendar year.
- ⇒ The provision establishing that the provider must be on the IPC of three (3) or more participants has been removed.
- ⇒ Provider has eighteen months from date the criteria are met to obtain accreditation.

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Section 25 establishes additional standards for providers that require national accreditation.

- Subsection (a) outlines that providers certified in the following services may be required to obtain and maintain national accreditation
  - Adult day;
  - Case management, which is an addition with this iteration of rule;
  - Community living;
  - Community support;
  - Companion, which is also an addition with this iteration of rule; and
  - Supported employment.
- If a provider delivers the services above, in any combination, for a total amount of \$150,000.00 or more per calendar year, the provider will be required to seek and maintain accreditation in all of the services on the list that they provided in that year, regardless of the number of people to whom they provided the services.
- The provider has eighteen months from the date the criteria are met, which would be the end of the calendar year, to obtain accreditation.

# Section 25 – Additional Standards for Providers that Require National Accreditation

## Implementation Strategy

- ⇒ Providers meeting criteria under current rule will be required to comply.
- ⇒ At the end of January 2021, the Division will send notification to providers that meet the established criteria. If billing is delayed, providers may receive their notification later in the year.
- ⇒ Providers will have until June 30, 2022 to come into compliance.
- ⇒ The Division will consider proposals for alternate case management accreditation.
  - Proposals should include the standards required by the proposed agency.

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This rule change received multiple comments during the community engagement sessions and public comment period. This recommendation was in response to a robust Rules Advisory Committee discussion on the importance of case management services, as well as the rate that the Division pays for these services. The Division accepted this recommendation, but understands that the additional requirement will need to be implemented in a thoughtful and reasonable way.

- This rule will apply to calendar year 2020 and beyond.
- The Division will begin notifying providers of their need to comply for calendar year 2020 at the end of January 2021. Provider notification may come later in the year if the provider delays its billing.
- Providers will have until June 30, 2022 to come into compliance for calendar year 2020, regardless of when the provider billed for services in 2020 or when they were notified by the Division.
- A similar process will be followed for subsequent years.
- The Division will consider proposals to accept case management accreditation from agencies other than CARF International or the Council on Quality and Leadership (CQL). Proposals should be submitted to the Division, and should include the standards required by the proposed agency.
- Finally, the Division is embarking on its next rate rebasing project. Accreditation costs for case management and companion services will be considered in this project.

## Section 28 – Provider Certification Renewal

### ⇒ Overall timeline established in rule:

- Division notifies provider of certification expiration at least ninety (90) calendar days prior to the certification expiration date (Section 28(a)).
- Providers submit verification that they have met all applicable certification renewal requirements at least forty-five (45) calendar days prior to the certification expiration date (Section 28(g)).
- Division notifies provider of the need for an on-site visit at least thirty (30) calendar days prior to the visit (Section 28(b)).
- If a provider fails to meet certification renewal requirements within 45 calendar days, the Division notifies the provider that the provider certification will expire (Section 28(h)).
- If the provider does not meet provider certification renewal requirements within twenty (20) calendar days of the certification expiration, the Division begins the decertification process (Section 28(h)(i)).

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Section 28 establishes the rules for provider certification renewal.

- Division timelines in this process have been revised somewhat.
  - The Division will notify a provider of their upcoming certification expiration at least 90 calendar days before the expiration date.
  - If the provider will need an on-site visit, the Division will notify the provider at least 30 calendar days prior to the visit.
- Provider timelines are the same, but we'd like to conduct a quick review.
  - Providers should submit all necessary information at least 45 calendar days prior to the expiration date.
  - If the provider doesn't submit 45 calendar days prior to the expiration, the Division will send the provider notification that the certification is going to expire.
  - If the provider doesn't submit 20 calendar days prior to the expiration, the Division will begin the decertification process.

## Section 28 – Provider Certification Renewal

**Attestations submitted as part of the certification renewal process are legally binding.**

- ⇒ Section 28(j) – Providers shall submit all certification renewal documentation and information. Providers shall not use outside entities to submit certification renewal information.

- The Division has heard anecdotally that some providers have their case managers or other entities complete the certification renewal process for them.
- The certification renewal process includes attestations, which are legally binding and can only be submitted by the provider.
- This provision has been added to Section 28(j) to clarify that **only** the provider can complete their provider certification renewal.

## Section 29 – Corrective Action Plan Requirements

**The Division has the authority to impose corrective action, and can require the provider to submit and implement a corrective action plan.**

- ⇒ Section 29(f) – If a corrective action plan is not ***submitted and*** implemented to address all areas of suspected non-compliance, the Division may impose sanctions as warranted in Section 30 of this Chapter.

Section 29 addresses the requirements of a corrective action plan.

- The Division can impose corrective action, and require a provider to submit and implement a corrective action plan if a violation of rule is identified.
- As we mentioned when we discussed Section 21, it has always been the Division's expectation that corrective action plans must be submitted and implemented.
- Subsection (f) has been revised to make this expectation clear.

## Section 30 – Sanctions

### **Decertification of a provider as a result of a sanction is a serious matter.**

- ⇒ Section 30(d) – A provider who has had their certification revoked under this Section shall not provide waiver services.
- ⇒ Providers must take reasonable steps to assure that they do not bill for services provided by an individual who has been decertified as part of a sanction.
  - Consider a question on the employment application that asks if the applicant has been decertified under Chapter 45, Section 30 of the Department of Health's Medicaid Rules.
- ⇒ Provider process must be in place by April 1, 2020.

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### Section 30 establishes the rules for sanctions.

- The Division can impose sanctions as a result of a provider's violation of rule.
- Sanctions can include conditions such as educational interventions, recovery of overpayments, and suspension of payments. The Division can also impose limits on case manager caseloads, can impose a monitor on providers, can impose civil monetary penalties, and can suspend provider certification.
- Unfortunately, the Division may identify a need to decertify a provider as part of an imposed sanction.
- If this occurs, the provider cannot provide services as a different entity, or as an employee of another waiver provider.
- Providers will be responsible for assuring that the employees they hire have not been decertified as part of a sanction under this Section, and must be able to demonstrate how this is done during their own provider certification renewal.
  - This might be demonstrated by including a question on the provider's employment application, specifically asking if the applicant has been decertified under Chapter 45, Section 30 of the Department of Health's Medicaid Rules.
- Providers have until April 1, 2020 to come into compliance with this rule.

# Chapter 46 – Medicaid Supports and Comprehensive Waivers

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Chapter 46 is entitled Medicaid Supports and Comprehensive Waivers, and establishes rules related to participant eligibility, waiver cost limits, emergency services, and the extraordinary care committee. There were fewer revisions made to the content of this Chapter, but the Sections look different than the previous version of rule.

## New Sections

- ⇒ Section 4 – Eligibility Requirements
- ⇒ Section 5 – Loss of Eligibility
- ⇒ Section 6 – Institutional Level of Care Requirements
- ⇒ Section 7 – Clinical Eligibility Diagnosis
- ⇒ Section 8 – Inventory for Client and Agency Planning Assessment

- In the previous version of Chapter 46, all eligibility and assessment information was contained within one section.
- These components have been separated into specific sections.
  - Section 4 specifically establishes the eligibility requirements, which include residency and financial eligibility, institutional level of care, clinical eligibility, and ICAP assessments.
  - Institutional level of care, clinical eligibility, and ICAP requirements are then addressed in separate sections.
- These changes are intended to make the eligibility process, and the rule itself, easier to understand.

## Section 11 – Waiver Cost Limits and Individual Budget Amounts

**Portions of this Section have been removed to decrease unnecessary wording.**

- |  |  |
|--|--|
| <p>⇒ Section 11(c) – Participants enrolled in the Supports Waiver shall be assigned a designated budget amount outlined in the most current Supports Waiver application, which is incorporated by reference.</p> | <p>⇒ Section 11(d)(i) – Participants enrolled on the Comprehensive Waiver shall be assigned an individual budget based on the following factors...</p> |
|--|--|

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Section 11 establishes rules related to waiver cost limits and individual budget amounts.

- Revisions to Section 11 resulted in several items being removed.
- As we mentioned at the beginning of the training, the Attorney General's office recommended that the Division remove wording that was not rule related.
- As a result, several portions were removed from this Section.
  - The Support Waiver purpose statement was removed.
  - Subsection (c) now cites the Supports Waiver application for the assigned budget amount, and the components of the calculation have been removed.
  - Subsection (d)(i) outlines the factors considered when determining a participant's individual budget amount for the Comprehensive Waiver. However, reference to the Level of Service scoring rubric has been removed since the scoring rubric is no longer utilized.

## Section 12 – Self-Directed Service Delivery

**A provider that has had their certification revoked under Chapter 45, Section 30 shall not provide services through self-direction.**

- ⇒ Section 12(i) – The employer of record shall hire employees to provide waiver services, and work with the Financial Management Service to determine that the potential employee meets the general and specific provider standards for the service being provided. ***A provider who has had their certification revoked under Chapter 45 of the Department of Health's Medicaid Rules shall not provide self-directed services.***

Section 12 establishes rules related to self-directed service delivery.

- As we discussed during the presentation of Chapter 45, Section 30, which addresses sanctions, the Division may identify a need to decertify a provider as part of an imposed sanction.
- If this occurs, the provider cannot provide services as an employee hired by an employer of record to provide services under self-direction.
- ACES\$, the agency that serves as Wyoming's Financial Management Service, will be implementing some changes to help identify potential employees who might fall into this category, but employers of record will be ultimately responsible for assuring that the employees they hire have not been decertified as part of a sanction under Chapter 45, Section 30.

## Section 13 – Wait List Process

**The Division maintains a wait list for individuals who are eligible for the waivers, but do not have a funding opportunity available to them.**

- ⇒ Section 13(e) – The Level of Service score and individual budget amount shall be determined for each individual on the wait list. An eligible individual who needs services in excess of the Supports Waiver may request placement on the Comprehensive Waiver, and may be placed on the Comprehensive Waiver wait list if a funding opportunity is not available. ***Preference on the Comprehensive Waiver wait list is given to individuals with a Level of Service score of four (4) or higher.***

Section 13 outlines the Division's wait list process.

- The Division maintains a wait list for individuals who are eligible for the waivers, but don't have a funding opportunity available to them.
- In past versions of rule, the Division required a person to have a level of service score of 4 or higher in order to be served on the Comprehensive Waiver.
- However, while priority is given to individuals with a level of service score of 4 or higher, having this level of service is not a requirement.
- Section 13(e) has been revised to clarify this point.

## Section 13 – Wait List Process

**The Division reserves capacity for individuals who have resided in Wyoming institutions and are ready to receive community services.**

- ⇒ Section 13(f) – The Comprehensive Waiver shall reserve capacity each year for eligible individuals who have resided in a Wyoming institution, such as an ICP/IID, nursing home, Psychiatric Residential Treatment Facility, residential treatment facility, BOCES, or an inpatient psychiatric hospital, and who have been:
- (i) In a residence at the institution;
  - (ii) On a Division wait list; or
  - (iii) On a Division waiver prior to being institutionalized.

- The Division reserves capacity for individuals who have resided in Wyoming institutions and are ready to receive community services.
- In order for the individual to be eligible for one of the reserved capacity slots, they must meet all eligibility requirements and one of the criteria outlined in Section 13(f).
- In past versions of rule, the Division required the individual to have met the criteria outlined in Section 13(f) for two years prior to being eligible for a reserved capacity slot. The two year requirement has been removed.

# Section 15 —

Extraordinary Care Committee

- (c)(iii)
- (f)
- (f)(iii)
- (i)
- (j)

Section 15 establishes the criteria for the Extraordinary Care Committee, or ECC. There were several revisions to this Section.

## Section 15(c)(iii) – Cases the ECC will Review

**Rule dictates the specific cases that the ECC will review.**

⇒ The ECC shall review:

- (i) Emergency cases as defined by Section 14 of this Chapter;
- (ii) Extraordinary cases that include a significant change in service need due to the onset of a behavioral or medical condition or injury; and
- (iii) *Other supplemental requests as defined in the Comprehensive and Supports Service Index, which is incorporated by reference.***

- Section 15(c) dictates the specific cases that the ECC will review. Requests that fall outside of this provision of rule will not be reviewed by the ECC.
- Subsection (c)(iii) has been added, which allows supplemental requests defined in the service index to be reviewed.
- This provision includes such requests as funding for additional supported employment services or home modifications that exceed the \$20,000 lifetime cap.

## Section 15(f) and (f)(iii) – Consensus and Credentialed Professionals

Team consensus is required before a request can be submitted to the ECC.

⇒ ***Before submission, the participant's plan of care team shall meet and come to a consensus that an ECC request is necessary and other support or resource options have been explored.*** The case manager shall ensure the request contains, at a minimum:

- (iii) Written statements from ***a credentialed professional*** related to the area of the concern, explaining the significant change in the participant's functioning limitations that result in an assessed need for additional supports or services and how the person's life or health is in jeopardy without such supports and services;

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- Section 15(f) requires the participant's plan of care team to agree that the ECC request is necessary before the request is submitted.
  - For the purposes of this rule, a consensus will be defined as a majority.
  - In addition to team consensus that the request is necessary, the team must also agree that other support or resource options have been explored.
- The Division has updated the ECC Request Form. The case manager must indicate on the form that the team was in consensus.
- If the Division receives a complaint regarding the ECC request process, or is notified that the team was not in consensus, Division staff will investigate.
- As of the date the new rules became effective, team consensus will need to be noted in the ECC request.
- Subsection (f)(iii) requires a written statement from a credentialed professional related to the area of concern.
- In past versions of rule, this statement had to come from a physician or licensed psychologist, but in some cases a therapist, such as a physical or occupational therapist, may be better able to explain the significant change in a participant's functioning limitations.

## Section 15(i) – Incomplete Requests can be Denied

**Section 15 establishes the minimum requirements that must be met in order for an ECC request to be reviewed.**

- ⇒ ECC requests that do not meet the criteria outlined in subsection (f) of this Section shall not be considered by the ECC.

- Section 15(f) establishes the minimum requirements for an ECC request. These requirements include:
  - Written statements or reports from other state or regional agencies that support the emergency case including specific incidents, notes related to the type of condition or injury, witnesses, follow up, treatment summaries, and documented accounts of events by witnesses;
  - Documentation of other approaches or supports that have been attempted;
  - The written statement from a credentialed professional related to the area of concern;
  - Evidence that the person doesn't qualify for funding or services through other agencies that could alleviate the emergency situation; and
  - Specific evidence if the person is requesting services due to homelessness.
- If all of these components are not included in the ECC request, Section 15(i) clarifies that the ECC will not consider the request.
- Case managers and plan of care teams are encouraged to review ECC requests before submitting them to the Division to assure all required components of the request are present.

## Section 15(j) – Teams Must Comply with Additional Requests from the ECC

**The ECC may request additional assessments, referrals, or outside consultation.**

⇒ ...The additional assessments and information may result in a level of service score increase, decrease, or no change. ***If the participant or plan of care team declines the additional requests, the ECC request shall be denied.***

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- The ECC has the authority to approve an ECC request on a short term basis, and require additional assessments, referrals, or outside consultation to gather additional information on a participant's specific circumstances.
- If the participant or plan of care team declines to adhere to the additional requests, Section 15(j) establishes that the ECC will deny the request.

# Section 16 – Prohibited Use of Waiver Funds

**Chapter 46 establishes services that are not eligible for waiver reimbursement.**

- ⇒ Section 16(b)(ii) – Waiver services may be used if an individualized educational plan identifies specific times when the school system shall not cover services for the individual.

Section 16 establishes services that cannot be paid with waiver funding

- Section 16(b) establishes that services that are the responsibility of the school system shall not be authorized as waiver services.
- However, subsection (b)(ii) clarifies that waiver services can be used if the individual educational plan identifies specific times when the school system shall not cover services for the individual.
- This provision of rule does not release the Department of Education from their obligations under the Individuals with Disabilities Education Act, or IDEA, but does provide some flexibility for individuals to receive needed services when the school district states it specifically won't provide services or supports.

# Wrap Up

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The topics discussed during this training include the most significant changes made to Chapters 44, 45, and 46 of the Department of Health's Medicaid Rules.

## Wrap Up

- ⇒ Find rules at <https://health.wyo.gov/healthcarefin/dd/dd-public-notice/> under the *Rules* tab.
- ⇒ Review Chapters in their entirety to have a better understanding of all of the revisions that have been made.
- ⇒ Address questions with your area Provider or Participant Support Specialist.
- ⇒ Attend regularly scheduled Provider and Case Manager Support Calls for ongoing training and information sharing.
  - Contact Shirley Pratt at [shirley.pratt@wyo.gov](mailto:shirley.pratt@wyo.gov) to be added to the Division email list.

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- We strongly encourage all stakeholders to review these Chapters in their entirety so you have an understanding of all of the revisions made. While this training has covered the more significant changes, it does not encompass all of the changes made.
- It is the responsibility of providers, case managers, and participants and their legally authorized representatives to be knowledgeable of the rules that govern the Comprehensive and Support Waiver programs.
- The rules can be found on the Public Notices, Regulatory Documents, and Reports page of the Division website, under the Rules tab. The web address is included in the slides.
- If you have specific questions regarding the rules, contact your area Provider or Participant Support Specialist.
- The Division offers ongoing training and information sharing during the monthly Case Manager Support Call, which is typically held on the second Monday of each month, and the Provider Support Call, which is typically held on the last Monday of the month. Both of these support calls are held at 2PM.
  - If you don't currently receive reminders of these calls, please contact Shirley Pratt at [shirley.pratt@wyo.gov](mailto:shirley.pratt@wyo.gov) to be added to the Division's email list.

# Questions

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We will now open for questions. Please add your questions to the chat box.